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The Impact of Disaster on the Reproductive Health of Women and Girls in Nigeria

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Abstract

The last two decades has witnessed an increase frequency and severity of both natural and man-made disasters in Nigeria. Women and girls are more affected by the impact of disasters, which due to their prior poor economic and social status limit their survival skills. The response to disaster in affected communities in Nigeria put more premiums on issues like shelter, food, water and sanitation, human security with less attention on reproductive health and social issues. Disaster and displacement expose women to sexual violence, exploitation, trafficking and abuse, leading to higher rates of unintended pregnancies, risky abortions, and sexually transmitted infections (STIs) as well as other latent issues. This paper assesses the impact of inaction and neglect of reproductive health and other social issues in disaster management. It is our conclusion that the emergency situation provides a possibility and opportunity to enhance knowledge and provide sexual and reproductive health services. Working with traditional authorities, local and national partners can facilitate the implementation of sexual and reproductive health services that also deal with related cultural norms and practices.

Key words: Reproductive health; Disaster management; Women's health; Sexual violence

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INTRODUCTION

The last two decades has witnessed a rise in the occurrence and severity of both natural and man-made disasters in Nigeria. Nigeria has experienced a number of disasters and emergencies such as erosion, plane crash, drought, pipeline explosion, political, and ethnic conflict. Due to the Boko Haram insurgency in the Northeast, thousands of people including women and children have lost their lives; others have been maimed or abducted. Several cities, markets, churches, parks, schools, and public buildings across the country are hit by bomb attacks. More recently, kidnapping of women and schoolgirls in addition to disguising as cattle herdsmen to raid innocent and unsuspecting communities is on the increase. In North central and some parts of Nigeria, there has been an escalation of communal violence due to competition between the nomadic herdsmen and local farming communities. Hundreds of thousands of people have been forced to flee their homes to neighbouring countries or other parts of the country due to natural disasters and violence. The preponderance of displaced persons in Nigeria is attributed to conflicts and wars particularly the Boko Haram insurgency. The Internal Displacement Monitoring Centre (n.d.) reported that Nigeria has about 1,707,000 displaced persons due to conflict, generalized violence, human rights violations and natural hazard-induced disasters as at the end of 2017. On their part, Lenshie and Yenda (2016) averred that 90 percent of internally displaced persons (IDPs) in the country is caused by the insurgency carried out by the Boko Haram sect in the Northeast with less than 10 percent caused by natural disasters. Since 2011, the population of the North East states of Nigeria have been affected by the insurgency between Boko Haram and governmental forces, this has led to an estimated 1.87 million internally displaced persons, (UNICEF, 2015) this has escalated the health challenges and compounded the country's poor health indices.

Lack of access to reproductive health care is among the cause of morbidity and mortality among women. The occurrence of a disaster disrupts women's access to sexual and reproductive health services with negative impact on their reproductive health status. The response to and management of disaster in the country put more premium on issues considered more critical to shelter, food security, water and sanitation, human security with less attention on reproductive health and social issues like abuse and trafficking with considerable negative impact on women and girls. Disaster and displacement expose women to sexual violence, rape, and exploitation leading to higher rates of unplanned pregnancies, unsafe abortions, and sexually transmitted infections (STIs) (Cohen, 2009) - a common occurrence that symbolizes dominance by the attackers and a conquered group. The loss of financial security within the family has attendant consequences including school dropout, psychological trauma, early and forced marriage, labor and trafficking all issues that do not manifest immediately.

This paper assesses the impact of the neglect of reproductive health and other social issues in disaster management on displaced women and girls in Nigeria. It is our conclusion and recommendation that the emergency situation provides a challenge as well as an opportunity to address the sexual and reproductive issues of women and enhance their access to health services.

1. DISASTER MANAGEMENT FRAMEWORK

The Sendai Framework for Disaster Risk Reduction (2015-2030) adopted by the United Nations to guide disaster risk management globally is an improvement of the Hyogo Framework. Nations are encouraged to adapt the Framework with clear targets and goals to reduce disaster risk and build communities and nations resilient to disaster. The United Nations Office for Disaster Risk Reduction (2015:13) opined that, "the Framework aims at achieving a valuable reduction of the risk of disaster and loss of lives, livelihood and health and in the social, cultural, physical, economic and environmental assets of persons, businesses, communities and countries." Four priority areas are highlighted in the framework for action to achieve the expected outcome and goals:

PRIORITY 1: Understanding disaster risk

PRIORITY 2: Strengthening disaster risk governance to manage disaster risk

PRIORITY 3: Investing in disaster risk reduction for resilience

PRIORITY 4: Enhancing disaster preparedness for effective response and to " Build Back Better" in recovery, rehabilitation and reconstruction.

Providing reproductive health-related services in conflict or disaster-affected and displaced populations is a critical but challenging undertaking particularly because the reproductive health-related needs of refugees, migrants and displaced people are seldom included in the country's responses to emergencies. The paper recommends that the Sendai Framework for Disaster Risk Reduction be adapted in the country to guide actions on preparedness and response to reproductive health issues in emergency and humanitarian situations in the country. Considerable attention should be accorded to the following:

Preparation: Many communities that accept migrants, host refugees or displaced people are already overburdened to provide these populations with the required health and reproductive health related services which, are seldom recognised as a priority in emergencies. We therefore advocate for a greater understanding of reproductive health issues and practices in disaster management particularly the dimensions of vulnerability, and exposure of persons, as well as the capacity and preparedness of institutions and facilities to respond.

Planning and reproductive health integration: Strengthening reproductive health integration into disaster management requires a distinct vision, competence, plans, guidance and coordination within and across sectors, as well as participation of relevant stakeholders. It is critical to an inclusive plan for a more effective implementation of interventions to protect persons, and protect health of people in disaster and emergency situation.

Coordination: At the community and Local government levels, the structures that can proactively work to prevent new and reduce existing disaster risk are considerably weak. They should be reconstituted and strengthened for the implementation of an integrated and inclusive plan for increase preparedness and response and resilience. This will minimized complains of relief materials not evenly distributed and accounted.

There is a need for a broader and a more people-centered preventive approach to reproductive health issues in emergency settings. This will require a multi-sectoral, inclusive and accessible approach such as regulatory and management role of Government engaging relevant stakeholders, including women, youth, migrants, volunteers, and community actors in the design and implementation of policies, and plans.

Reproductive health in disaster management: The Federal and State Ministries of Health in line with their responsibilities to proactively and sustainably manage and coordinate health related issues in any disaster or emergency situation should have an established unit with a mandate to respond to health and reproductive health issues in disaster or emergency. The unit should be capacitated to manage, monitor, assess health related issues and, coordinate relevant institutions and organization intervening in health.

Role of stakeholders: The responsibility for disaster management is shared between the different levels of Governments in Nigeria, with a significant role for

relevant stakeholders and non-State actors. The roles of the different stakeholders should be clearly defined and understood in compliance with national laws, policies and regulations. There should be a more effective coordination, monitoring and feedback by the Federal and the State Emergency Management Agencies to ensure that the issues affecting displaced persons are addressed and duplication avoided.

2. CURRENT REPRODUCTIVE HEALTH INDICES OR INDICATORS IN NIGERIA

In spite of policies and programs geared towards achieving suitable reproductive health indices in the country, demographically speaking, available reproductive health data is a pointer that we still have a long way to go in achieving the desired result even among stable populations. Nigeria's health indices especially in Northern part of the country are among the worst in the world (Omo-Aghoja, 2013), skillful birth attendants take only 35 percent of deliveries and only less than 20 percent of health facilities offer emergency obstetric care as women and children continue to suffer from poor coverage and quality of health care services in Nigeria (UNICEF, 2016 cited by Enang and Undelikwo, 2016). According to the Nigerian Demographic and Health Survey (2013:135), "compared with 35 percent in 2008, 36 percent of births in the country are delivered in a health facility indicating only a 1 percent growth between 2008 and 2013." UNICEF (n.d.) reported that the country has a maternal mortality ratio of 576 deaths per 100,000 live births… approximately six women die during pregnancy, childbirth or within two months of giving birth. Every day, 145 women of reproductive age die in Nigeria making her the second country with largest maternal mortality rate in the world. On the other hand, 1 in 13 women are likely to die from pregnancy and childbirth. Similarly, in every 10 minutes, a woman dies from pregnancy and childbirth giving a total of 53,000 per year (UNICEF, n.d).

Despite the above scenario, it is noted that there exists a wide disparity among the regions that make up Nigeria. For instance, UNICEF (n.d) noted that compared to 165 live births in Southeast, the Northeast has the highest maternal mortality rate of 1,549 per 100,000 live births an almost ten fold difference. The North West and the South East have 1,026 and 286 maternal mortality per 100,000 live births respectively. This situation has been worsened by the Boko Haram crisis.

The knowledge and use of contraceptives are one of the conscious efforts in reducing the level of unwanted pregnancies in all women of childbearing age as well as the reduction in the spread of HIV/AIDS and other sexually transmitted infections. The Nigerian Demographic and Health Survey (2013) reported a widespread knowledge of any contraceptive method in Nigeria, with 85 percent and 95 percent of women and men respectively knowing at least one method of contraception. Information on current use of contraception revealed that 15 percent of currently married women in Nigeria is using a contraceptive method. This shows an increase of only 2 percent since the 2003 National Demographic and Health Survey. This figure shows that knowledge does not translate to use.

3. THE IMPACT OF DISASTER ON THE REPRODUCTIVE HEALTH OF WOMEN AND GIRLS

The mid-1990s marked a global awareness for an urgent response to the reproductive health needs and rights of persons affected by natural disasters and conflicts. The emergence of consensus documents following the 1994 International Conference on Population and Development and the 1995 Fourth World Conference on Women posited that all women have the same reproductive health rights regardless of prevailing societal circumstances. The prevailing traditional view was that reproductive health care for people in emergency situations was a relative luxury, compared with the need for food, clean water, shelter, security, and primary health care (Cohen, 2009).

This report stimulated a concerted effort at the global level that led to the development of the "Reproductive Health in Refugee Situations" which was an Inter-agency field manual in 1999. The report also stipulated the Minimum Initial Services Package for Reproductive Health in tackling the immediate reproductive health needs of displaced persons in the earliest phases of emergencies especially as it concerns women and girls (Cohen, 2009). Its five key objectives are:

- Identify those responsible for the coordination and implementation of the minimum initial services package;
- The prevention of sexual violence, treatment and supporting survivors;
- The reduction of HIV transmission via universal precautions, free accessibility to condoms as well as safe blood supply:
- The prevention of unwanted baby and maternal mortality and disability; and
- Plan for the inclusion of reproductive health services beyond the emergency phase as a vital part of primary health care.

Countries have made efforts in realizing the above objectives, but much is still left undone especially in developing countries of the world. The United Nations Fund for Population Activities (2015) reported that though in the past decade, notable progress has been made in protecting the rights and health of women and girls in crisis situations, the increase in needs far outgrows the available funds and services provided. Though, these

services are seen to be very important especially for the teenage girls, who are considered the most susceptible group and the least able to face the several challenges they encounter even in crisis free and stable times. "In emergency situations and in fragile states, 507 women and adolescent girls die as a result of pregnancy and complications of childbirth everyday" (United Nations Fund for Population Activities, 2015:15).

Disaster and displacement expose women to the risk of sexual violence, exploitation, trafficking and abuse, leading to higher rates of unintended pregnancies, unsafe abortions, and sexually transmitted infections (STIs) as well as other reproductive health issues. According to the United Nations Fund for Population Activities (2015), in the 14 worst affected districts in the earthquake that occurred in 2015 in Nepal, about 5.6 million people were affected out of which about 1.4 million were women of reproductive age. A UNDP (2010) report revealed that four days after the first stroke, an estimate of 93,000 pregnant women were affected by the same disaster. A similar report by the United Nations Office for the Coordination of Humanitarian Affairs (2015:2) also showed that, "32 percent of the health facilities providing emergency obstetric maternal and neonatal care were destroyed following the disaster". "28,000 women were at risk of sexual violence in the districts most affected by the earthquake" (UNFPA, 2015:2).

Pregnant women and mothers of newborn babies are among the most vulnerable population in the emergency phase during a disaster or crisis. In 2015, 61 percent of maternal deaths in the world occurred in countries affected by an emergency situation or fragile conditions (UNFPA, 2016). During this phase, the vulnerable population requires attention as well as adequate nutrition, sufficient medicine, and antenatal care to deliver safely. Unfortunately, disaster or crisis situations results in either destruction or overcrowding with injured people of most of the health centers, village health posts, and birth-giving centers and hospitals making it difficult for pregnant women and new mothers to find safe and adequate conditions for delivery and maternal care, consequently increasing complications for deliveries, maternal mortality, and miscarriage following a disaster. UNFPA (2016:23) reported that, "due to insecurity, lawlessness and the destruction of health facilities and other infrastructure, women are unable to access life saving health services in emergency situations. In most cases, getting to the nearest maternal clinic or hospital can prove life threatening."

With increased risk of sexual abuse, unwanted pregnancies, abortions and sexually transmitted infections including HIV will be on the rise during a disaster situation. Reduced access to reproductive health services such as family planning methods resulting from disasters may also contribute to increased incidence of unwanted/ unplanned pregnancies. Following a disaster, for fear of sexual assault women tend to avoid using shelter and are more vulnerable to domestic and sexual violence (UNDP Bureau for Crisis Prevention and Recovery, 2010). The risk of rape and sexual assault is enhanced in facilities where there is no privacy. Children are also vulnerable to sexual abuse and exploitation in unfamiliar and over-crowded conditions.

Child marriage is a practice that may grow following a disaster. Disaster or crisis may further worsen the socioeconomic status of the poorest in the affected communities. As a coping mechanism, some widows may engage in this practice due to new responsibilities. "To avoid their daughters being raped in refugee camps after the 2004 tsunami in Indonesia, some parents adopted the child marriage strategy" (Singh, 2012: 11).

Early marriage has many negative impacts on young women's health such as death at childbirth, development of vesico vaginal fistula during childbirth, increased risk of delivering low-weight babies, as well as impacts on education and employment opportunities, and thus it limits their future choices. Also, giving birth at an early age may also halt the physical development of these girls

4. REPRODUCTIVE HEALTH AND OTHER SOCIAL ISSUES WITH REFERENCE TO DISASTER COMMUNITIES IN NIGERIA

After India, Nigeria has the second highest absolute numbers of maternal mortality in the world (Okonofua, 2010) and this has being compounded with the numerous disasters plaguing the country. UNFPA (2015) opined that in conflicts and crisis, women and girls are susceptible to pregnancy and childbirth. Sixty percent of avoidable maternal mortality occurs among women struggling to survive natural disasters, displacement and conflicts. On their part, the Population Reference Bureau (2002) observed that, many refugees and displaced persons have significant health problems in their place of residence before their displacement. Most of them come from places with low life expectancies and high maternal and newborn mortality, which may be exacerbated by displacement. Okanlawon, Reeves and Agbaje (2010) citing the Women's commission for Refugees, reiterated that the public health community has acknowledged the fact that young refugees are in danger to unplanned pregnancies and other reproductive health risks such as commencing sexual debut at an early age, unprotected sex and sexual exploitation.

The Nigerian Guardian Newspaper of 19th June, 2015 reported that in a teleconference with newsmen in Abuja, the Commissioner of Health in Borno state opined that, "we are still receiving a lot of IDPs coming. In the last week, we received over 6000 IDPs. Almost 80 percent are women and children. Also, we are receiving a lot of women that are pregnant, and a lot of them are having babies within the camp. The major challenge also is the

human resources, particularly nurses and midwives." Similarly, Nsofor (2015) found that in a Pro-Health International Life free medical care for IDPs in Oronzo, New Kunchingoro and Old Kunchingoro IDPs camps in Abuja, the pregnant women who were seen by the volunteers have never attended antenatal clinics; one was in her eighth month of pregnancy. The United Nations Office for Coordination of Humanitarian Affairs (2014:2) on Nigeria update in Internal Displaced Persons in camp and host communities in Adamawa State observed that, "among the top three needs of the affected population, health was the commonly cited." The State Emergency Management Agency reported reproductive health issues with deliveries by untrained birth attendants and cases of diarrhea among children. In host communities, prior to the crisis, health facilities were poorly staffed and supplied.

Premiere Urgence Internationale (2016) in agreement opined that a focus group discussion in Maiduguri brought out the fact that pregnant women do not have access to antenatal care, and some of them have given birth while fleeing and had no access to healthcare afterwards. Beyond access to services, the health conditions and status have most certainly worsened due to the crisis. The plights of pregnant women in crisis situations across Nigeria are the same with limited or no access to antenatal health services. In an interview by *Thisday Newspaper* reporter Bassey Inyang (2016) Chief Asuquo Etim the leader of the Bakassi refugees in the camp reported thus:

> Since 2008 that Nigeria kept us here in this camp, we have been facing hardship from hunger, illness and death. Criminals come here, and they attack us with knives and guns, rob us and even rape our women. Our women give birth here without any doctors and nurses to help, and some of the women and children die because there is no money to buy medicine in Ikang and we don't have money to take them to hospital.

Inyang further reported that after an official visit to the displaced people in Bakassi in the first camp at Ikang on May 12, 2016, 24 hours after her visit, the Director General of the Cross River State Primary Health Care Development Agency, Dr Betta Edu wrote on her face book page "I have not been myself since yesterday when I visited the IDPs in Bakassi camp 1… I was taken through 10 'fresh' graves of mothers and children at the camp."

The occurrence of gender-based violence is one of the reproductive health challenges confronting women and girls, and is usually exacerbated during a disaster. Supporting this assertion, UNFPA (2015:23) reported that, "when crisis strikes, girls become vulnerable and their prospects go from bad to worse. They may become the target of sexual violence, infected with HIV or pregnant the moment they reach puberty." The Boko Haram insurgents in Nigeria have adopted sexual violence to intimidate and subdue the population. The celebrated abduction of over 200 Chibok schoolgirls is an example. In a report in the Guardian Newspaper 19th June, 2015, Anuforo, Ojugbana and Alade observed that in the Makohi camp in Yola, Adamawa State, women and girls are enduring the trauma of being abducted, abused and raped. "There was other tales of terror in the camp, such as a 24-year-old woman who was abducted and was forced to marry one of the insurgents as a fourth wife, and the 16-year-old girl who delivered in the forest without any medical aid" (UNFPA, 2015:23). The Protection Sector Working Group (PSWG) assessment cited by the ACAPS crisis profile report (2016) in the Northeastern Nigeria, found that the vulnerabilities of women and children are of serious concerns. Of the 26 sites assessed in May 2016, there were reports of rape in 12 sites and survival sex or sexual exploitation in 14 sites while girls under 15 years being pregnant during rape were married off by their parents. In a similar assessment of Southern Borno by Mercy Corps (2016), higher levels of gender-based violence within internally displaced person households than before the displacement was a major concern raised during the survey and focus group discussions held with IDP adolescent girls.

A rapid protection assessment in Borno State conducted by the Protection Sector Working Group Nigeria (2016) found that the incidence of rape was a common phenomenon across the various camps housing the IDPs. Rape cases are reported in Dalori ii, Farm center camp, Bakassi camp, NYSC camp, Kululori host community, Shehu Sandi Karimi camp, EYN CAN center, Teacher's Village, Mogolis, Goni Kachallari camps as well as Kushari host community and mostly those in authority perpetrate this act.

Similar trends occurred during conflicts in several African countries were women were subjected to rape and sexual violence. During the 1999 conflict in Sierra Leone, over 50 percent of women experienced some forms of sexual violence (Swatzyna and Pillai, 2013). In a similar vein, almost 500,000 women were raped during the Rwanda genocide and about 5,000 pregnancies resulted from the rape. Okanlawon, Reeves and Agbaje (2010) argued that in displaced situation, which usually result in poverty, loss of security and helplessness, adolescent refugee women might be forced to engage in risky behaviors like prostitution and trading for food or protection to survive. This was found in Borno State where many of the adolescent Internal Displaced Persons girls interviewed using the Cohort Livelihoods and Risk Analysis (CLARA) tool revealed an increasing prevalence among this group of being forced to use high-risk coping strategies to have enough money (or in kind, food) for their families to eat, notably engaging in transactional sex (Mercy Corps, 2016). A similar assessment conducted in Borno reported that in farm center camp, women reported that many women in the camp have had to exchange sex for food, including a few of the women in the focus group. The issue was said to be widespread in the camp. One woman stated that maybe half of the women she knows in the camp have had to sleep with service providers for food

assistance (Protection Sector Working Group Nigeria, 2016).

According to the World Health Organization (2016), the ability of a woman to choose, limit and space her pregnancies is directly correlated with her health and well being as well as on pregnancy out come and a reduction of the need for unsafe abortion. There is a 3 percent contraceptives use in North Eastern Nigeria according to the Nigerian Demographic and Health Survey 2013 report, which is compounded by the Boko Haram insurgency due to the inaccessibility of contraceptives especially in internally displaced persons camps. A study by Okanlawon, Reeves and Agbaje (2010) in Oru refugee camp in Nigeria using a sample of 208 refugee youths aged 10- 24 with 92 males and 116 females found that at last sex prior to the study, 67.2 percent of the female averred that they had engaged in unprotected sex without using any contraceptives in the camp. The study equally found that about 50 percent of the female refugee youths studied were mothers- many of whom are school dropout due to recent unintended pregnancy. Accessibility to contraceptives was a challenged as 60 percent of all respondents had complained that they did not know any contraceptive source close to the camp.

Following a disaster, the age at which girls get married may be affected. The Protection Sector Working Group (2016), rapid protection assessment in Maiduguri during a focus group discussion with boys in the Farm Center camp reported that their sisters were getting pregnant out of marriage and that their parents were getting the girls married to men both inside and out of the camp to prevent stigma due to the pregnancy. The boys identified at least twenty such cases of forced early marriage with the majority of the girls being under 15 years old. Similar findings were also made in the EYN CAN center camp where parents reported that for fear of sexual abuse/ pregnancy, they would prefer to marry their daughters off. Such forced marriage to prevent sexual exploitation was also in Damboa Road host community camp.

Women and girls who test positive to HIV is one of the reproductive health concerns affecting women in disaster due to sexual violation and rape. The exchange of sex for food and other necessities predisposes women to sexually transmitted infections including HIV/ AIDS especially due to non-use of condom. Mr Hassan Mustapha, the Coordinator on HIV/AIDS in Borno State during an interview reported that in 27 camps, 5,000 internally displaced persons are currently living with HIV/ AIDS and most of the patients were women rescued from Boko Haram captivity (Premium Times, 2016).

RECOMMENDATIONS

The following recommendations are put forward from the preceding:

i The Government should leverage on the knowledge of reproductive health issues in disaster in order to effectively prevent the risk drivers and vulnerability to abuses and also plan appropriate actions and responses in the event of disasters.

ii There is a need to foster a partnership of all relevant stakeholders to work more closely to integrate reproductive health in disaster risk management practices.

iii The challenges with our Primary Health Care and Health systems generally, makes it imperative to address existing capacity issues and focus on institutional strengthening while health personnel are deployed to disasters and emergency communities to attend to the reproductive needs of women and girls.

iv There should be a more effective coordination, monitoring and feedback by the Federal and the State Emergency Management Agencies to ensure that the issues affecting displaced persons are addressed and duplication avoided.

v Those involved in cases of abuse, rape and trafficking of vulnerable women and girls in disasters and emergency communities should be appropriately sanctioned to serve as deterrence.

CONCLUSION

It is our conclusion that the emergency situation provides a possibility as well as an opportunity of enhancing knowledge of sexual and reproductive issues and health services. Working with traditional authorities and the local and national health partners can facilitate the coordination and implementation of sexual and reproductive health services that also deal with health-related cultural norms and practices.

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